

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0023036</div> <div>Facility Name: BAYSIDE TERRACE</div> <div>Address: 1100 SOUTH LEWIS WAUKEGAN 60085</div> <div>County: LAKE</div> <div>Telephone Number: (847) 244-8196 Fax # (847) 244-7647</div> <div>IDPA ID Number: 362886600001</div> <div>Date of Initial License for Current Owners: 1976</div> <div>Type of Ownership:</div> <div><div><div><div><input type="checkbox"/></div><div>VOLUNTARY,NON-PROFIT</div><div><input type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div><div>IRS Exemption Code</div></div><div><div><input checked="" type="checkbox"/> PROPRIETARY</div><div><input type="checkbox"/> Individual</div><div><input checked="" type="checkbox"/> Partnership</div><div><input type="checkbox"/> Corporation</div><div><input type="checkbox"/> "Sub-S" Corp.</div><div><input type="checkbox"/> Limited Liability Co.</div><div><input type="checkbox"/> Trust</div><div><input type="checkbox"/> Other</div></div><div><div><input type="checkbox"/> GOVERNMENTAL</div><div><input type="checkbox"/> State</div><div><input type="checkbox"/> County</div><div><input type="checkbox"/> Other</div></div></div></div> <div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div></div> <div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) ROBERT A. ROSE, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax# (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	168	Intermediate (ICF)	168	61,320	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	52,195	1,632	2,506	56,333	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,195	1,632	2,506	56,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.87%

D. How many bed-hold days during this year were paid by Public Aid?
896 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/3/1976

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BAYSIDE TERRACE** # **0023036** Report Period Beginning: **01/01/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	227,582	30,182	7,350	265,114		265,114		265,114			1
2	Food Purchase		240,800		240,800		240,800	(69)	240,731			2
3	Housekeeping	108,738	32,659		141,397		141,397		141,397			3
4	Laundry	18,088	6,869		24,957		24,957		24,957			4
5	Heat and Other Utilities			93,375	93,375		93,375	359	93,734			5
6	Maintenance	74,319	2,639	79,697	156,655		156,655	(27,076)	129,579			6
7	Other (specify):*											7
8	TOTAL General Services	428,727	313,149	180,422	922,298		922,298	(26,786)	895,512			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	739,596	76,714	35,086	851,396		851,396	(48,453)	802,943			10
10a	Therapy			3,158	3,158		3,158		3,158			10a
11	Activities	102,462	7,743		110,205		110,205	(1,086)	109,119			11
12	Social Services	249,921	1,818	378	252,117		252,117		252,117			12
13	Nurse Aide Training											13
14	Program Transportation			3,054	3,054		3,054		3,054			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,091,979	86,275	42,876	1,221,130		1,221,130	(49,539)	1,171,591			16
	C. General Administration											
17	Administrative	83,583		573,793	657,376		657,376	(451,543)	205,833			17
18	Directors Fees											18
19	Professional Services			78,683	78,683		78,683	(22,121)	56,562			19
20	Dues, Fees, Subscriptions & Promotions			27,265	27,265		27,265	(16,762)	10,503			20
21	Clerical & General Office Expenses	132,825	18,820	37,333	188,978		188,978	(24,747)	164,231			21
22	Employee Benefits & Payroll Taxes			258,755	258,755		258,755	1,865	260,620			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,916	7,916		7,916	(3,471)	4,445			24
25	Other Admin. Staff Transportation			440	440		440		440			25
26	Insurance-Prop.Liab.Malpractice			51,098	51,098		51,098	(708)	50,390			26
27	Other (specify):*							5,578	5,578			27
28	TOTAL General Administration	216,408	18,820	1,035,283	1,270,511		1,270,511	(511,909)	758,602			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,737,114	418,244	1,258,581	3,413,939		3,413,939	(588,233)	2,825,706			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			107,434	107,434		107,434	5,487	112,921			30
31	Amortization of Pre-Op. & Org.			2,709	2,709		2,709		2,709			31
32	Interest			25,543	25,543		25,543	(22,997)	2,546			32
33	Real Estate Taxes			73,752	73,752		73,752		73,752			33
34	Rent-Facility & Grounds							5,544	5,544			34
35	Rent-Equipment & Vehicles			5,293	5,293		5,293		5,293			35
36	Other (specify):*											36
37	TOTAL Ownership			214,731	214,731		214,731	(11,966)	202,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			77,870	77,870		77,870	(77,870)				41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			169,850	169,850		169,850	(77,870)	91,980			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,737,114	418,244	1,643,162	3,798,520		3,798,520	(678,069)	3,120,451			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,488	30		9
10	Interest and Other Investment Income	(11,562)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,729)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,745)	21		24
25	Fund Raising, Advertising and Promotional	(11,005)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,954)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(186,399)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (233,974)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(444,095)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (444,095)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (678,069)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	Non-Care Asset Depreciation	\$ (1,775)	30
2	Penalties	(311)	21
3	Trust Fees	(200)	21
4	Vending Income Offset	(77,870)	41
5	Non-Allowable Accounting Fees	(22,079)	19
6	Non-Allowable Legal Fees	(500)	19
7	Capitalized R&M	(27,092)	6
8	Craft Sale Income (misc income)	(1,086)	11
9	Out of State Seminar	(759)	24
10	VA Expenses (Pharmacy, Lab and Physician)	(48,453)	10
11	Non-allowable seminar travel	(2,712)	24
12	Non-allowable Holiday Expense	(100)	22
13	ICLIC COPI Dues	(2,359)	20
14	Bank Charges	(496)	21
15	PPA - Insurance	(807)	26
16			16
17			17
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90			90
91			91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BAYSIDE TERRACE# 0023036

Report Period Beginning:

01/01/01

Ending:

12/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(69)											(69)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			359									359	5
6	Maintenance	(27,092)		16									(27,076)	6
7	Other (specify):*													7
8	TOTAL General Services	(27,161)		375									(26,786)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(48,453)											(48,453)	10
10a	Therapy													10a
11	Activities	(1,086)											(1,086)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(49,539)											(49,539)	16
	C. General Administration													
17	Administrative			(17,000)	(274,616)	(159,927)							(451,543)	17
18	Directors Fees													18
19	Professional Services	(22,579)		195	88	175							(22,121)	19
20	Fees, Subscriptions & Promotions	(17,093)		331									(16,762)	20
21	Clerical & General Office Expenses	(28,506)		3,759									(24,747)	21
22	Employee Benefits & Payroll Taxes	(100)		1,965									1,865	22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,471)											(3,471)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(807)		99									(708)	26
27	Other (specify):*				1,823	3,755							5,578	27
28	TOTAL General Administration	(72,556)		(10,651)	(272,705)	(155,997)							(511,909)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,255)		(10,276)	(272,705)	(155,997)							(588,233)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,713		774									5,487	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(11,562)	(11,435)										(22,997)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			5,544									5,544	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(6,849)	(11,435)	6,318									(11,966)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(77,870)											(77,870)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(77,870)											(77,870)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(233,974)	(11,435)	(3,958)	(272,705)	(155,997)							(678,069)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Bayside Terrace Highland Park		Escrow
				Note Partnership		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
Item	Line								
1	V	32	Mortgage Interest	\$ 11,435	Bayside Terrace Partnership	100.00%	\$	\$ (11,435)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 11,435			\$	\$ * (11,435)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 359	\$ 359	15
16	V	6	REPAIRS AND MAINT.		A.H.B. D/B/A ABH MANAGEMENT	100.00%	16	16	16
17	V	19	PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	195	195	17
18	V	20	DUES, SUBS. & FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	331	331	18
19	V	21	CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	3,759	3,759	19
20	V	22	EMPLOYEE BENEFITS		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,965	1,965	20
21	V	26	INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	99	99	21
22	V	30	DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	774	774	22
23	V	34	RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	5,544	5,544	23
24	V								24
25	V	17	HOME OFFICE	17,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(17,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 17,000			\$ 13,042	\$ * (3,958)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 39,000	\$ 39,000	15
16	V	19	PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	88	88	16
17	V	27	PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	1,823	1,823	17
18	V								18
19	V	17	MANAGEMENT FEES	313,616	HEALTH RESOURCE, INC.	100.00%		(313,616)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 313,616			\$ 40,911	\$ * (272,705)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 83,250	\$ 83,250	15
16	V	19	PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	175	175	16
17	V	27	PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	3,755	3,755	17
18	V								18
19	V	17	MANAGEMENT FEES	243,177	KARLA BISHOP, INC.	100.00%		(243,177)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 243,177			\$ 87,180	\$ * (155,997)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Earl Rosenbaum	General Partner	Fin. Operation	33.21%	See Attached	10	25.00%	Officer Sal.	\$ 39,000	17-7	1
2	Karla Bishop	General Partner	Administration	6.55%	See Attached	20	50.00%	Admin. Sal.	83,250	17-7	2
3	Pam Price	Relative	LPN			40	100.00%	LPN Salary	31,428	10-1	3
4	Jack Bishop	Relative	Maintenance			40	100.00%	Maintenance	45,598	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 199,276		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number BAYSIDE TERRACE# 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENTStreet Address 411 CENTRAL AVENUECity / State / Zip Code HIGHLAND PARK, IL. 60035Phone Number (847)432-7262Fax Number (847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	142,822	3	\$ 911	\$	56,333	\$ 359	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	142,822	3	40		56,333	16	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	142,822	3	495		56,333	195	3
4	20	DUES, SUBS. & FEES	PATIENT DAYS	142,822	3	839		56,333	331	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	142,822	3	9,530		56,333	3,759	5
6	22	EMPLOYEE BENEFITS	PATIENT DAYS	142,822	3	4,982		56,333	1,965	6
7	26	INSURANCE	PATIENT DAYS	142,822	3	250		56,333	99	7
8	30	DEPRECIATION	PATIENT DAYS	142,822	3	1,963		56,333	774	8
9	34	RENT	PATIENT DAYS	142,822	3	14,055		56,333	5,544	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 33,065	\$		\$ 13,042	25

Facility Name & ID Number BAYSIDE TERRACE

0023036

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

HEALTH RESOURCE, INC.

Street Address

P.O. BOX 1275

City / State / Zip Code

HIGHLAND PARK, IL. 60035

Phone Number

(847)432-7262

Fax Number

(847)432-6095

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED 40	3	\$ 156,000	\$ 156,000	10	\$ 39,000	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 40	3	350		10	88	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED 40	3	7,292		10	1,823	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 163,642	\$ 156,000		\$ 40,911	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization KARLA BISHOP, INC.
Street Address 271 RIVERS DRIVE
City / State / Zip Code LAKE BLUFF, IL. 60044
Phone Number (847)432-7262
Fax Number (847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED	40	3	\$ 166,500	\$ 166,500	20	\$ 83,250	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	350		20	175	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3	7,510		20	3,755	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 174,360	\$ 166,500		\$ 87,180	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number BAYSIDE TERRACE # 0023036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Ending: 12/31/01**Fax Number**

Facility Name & ID Number

BAYSIDE TERRACE# **0023036**

Report Period Beginning:

01/01/01

Ending:

12/31/01**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bayside Terrace Note	x		Mortgage	\$8,905	1/25/94	\$ 574,724	\$	10/25/01	10.00%	\$ 3,815	1	
2	Americal National Bank		x	Industrial Revenue Bond	Variable	6/9/94	488,602	164,037	10/15/05	prim x.75	11,240	2	
3												3	
4												4	
5												5	
	Working Capital												
6	HMS		x	Fixed Assets	\$5,205	2/1/01	60,000	10,314	2/1/02		2,347	6	
7	Americal National Bank		x	Fixed Assets	\$2,535	1/31/01	125,000	105,749	1/31/06	8.00%	8,141	7	
8												8	
9	TOTAL Facility Related				\$16,645		\$ 1,248,326	\$ 280,100			\$ 25,543	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11	Interest Income										(11,562)	11	
12	Interest Income-Note Ptshp	x									(11,435)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (22,997)	14	
15	TOTALS (line 9+line14)						\$ 1,248,326	\$ 280,100			\$ 2,546	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number

BAYSIDE TERRACE

0023036

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2000 report.				\$	71,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	69,543	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,057)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	75,809	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	73,752	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	64,783	8	FOR OHF USE ONLY	
		1997	66,405	9		
		1998	67,580	10	13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
		1999	67,019	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2000	69,543	12	15	LESS REFUND FROM LINE 6 \$ 15
2001 Accrual = 2000 tax + over accrual + 3%						
69543 + 2057 = 71600 * 1.06 = 75809 (rounded)						
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

BAYSIDE TERRACE

COUNTY

LAKE

FACILITY IDPH LICENSE NUMBER

0023036

CONTACT PERSON REGARDING THIS REPORT

Steven Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1166

A.

Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	08-32-107-102	Long Term Care Property	\$ 69,542.98	\$ 69,542.98
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 69,542.98	\$ 69,542.98

B.

Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.

Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	104,671	1976	\$ 100,000	1
2					2
3	TOTALS	104,671		\$ 100,000	3

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	119			1976	\$ 1,082,366	\$	35	\$ 40,844	\$ 40,844	\$ 1,059,410	4
5	49			1986	630,167		35	18,005	18,005	282,106	5
6				1986	43,252		35	1,236	1,236	19,365	6
7											7
8											8
	Improvement Type**										
9	Various			1977	1,498		20	-		1,498	9
10	Various			1978	7,531		20	-		7,531	10
11	Various			1979	14,356		20	-		14,356	11
12	Various			1980	4,020		20	-		4,016	12
13	Various			1981	11,197		20	-		11,155	13
14	Various			1982	16,226		20	-		16,226	14
15	Various			1983	17,495		20	-		16,783	15
16	Various			1984	15,752		20	762	762	15,111	16
17	Various			1985	11,170		20	609	609	10,172	17
18	Various			1986	17,867		20	945	945	14,736	18
19	Various			1987	22,247		20	1,171	1,171	16,749	19
20	Various			1988	21,019		20	1,107	1,107	14,838	20
21	Various			1989	26,162		20	1,308	1,308	15,914	21
22	Various			1990	9,005		20	450	450	5,191	22
23	Various			1991	47,502		20	2,374	2,374	24,179	23
24	Various			1992	13,226		20	749	749	7,134	24
25	Various			1993	39,155		20	1,958	1,958	16,456	25
26	Various			1994	11,363		20	568	568	4,079	26
27	Various			1995	3,826		20	191	191	1,251	27
28	Various			1996	53,988		20	2,700	2,700	15,468	28
29	Various			1997	15,489		20	776	776	3,471	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	-	-		-		-	68
69	Financial Statement Depreciation		68,033			(68,033)		69
70	TOTAL (lines 4 thru 69)	\$ 2,135,879	\$ 68,033		\$ 75,753	\$ 7,720	\$ 1,597,195	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE

0023036

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,135,879	\$ 68,033		\$ 75,753	\$ 7,720	\$ 1,597,195	1
2	VINYL FLOORING	1998	1,050		20	53	53	199	2
3	PAINT KITCHEN	1998	806		20	40	40	80	3
4	COMPRESSOR	1998	1,786		20	89	89	178	4
5	VINYL FLOOR	1998	1,050		20	53	53	106	5
6	HUMIDIFIER	1998	1,600		20	80	80	160	6
7	HUMIDIFIER	1998	1,158		20	58	58	116	7
8	MASONRY REPAIR	1998	1,570		20	79	79	158	8
9	COMPUTER WIRING	1998	2,000		20	100	100	200	9
10	CUBICLE CURTAINS	1998	2,260		20	113	113	226	10
11	GENERATOR	1999	13,884		20	284	284	734	11
12	GENERATOR WIRING	1999	1,755		20	88	88	227	12
13	CUSTOM DOORS	1999	3,838		20	192	192	464	13
14	INSTALL GENERATOR	1999	1,342		20	67	67	173	14
15	DRAIN TILE REPAIR	1999	2,000		20	100	100	233	15
16	REMOVE&INSTALL DOORS	1999	1,498		20	75	75	175	16
17	KITCHEN REMODELING	1999	2,302		20	115	115	268	17
18	ROOFTOP HTG & A/C	1999	6,410		20	321	321	696	18
19	GUTTER REPAIR	1999	2,325		20	116	116	338	19
20	FURNACE REPAIR	1999	782		20	39	39	111	20
21	HOT WATER HEATER REP	1999	648		20	32	32	83	21
22	HOT WATER HEATER	1999	1,315		20	66	66	165	22
23	FREEZER REPAIR	1999	995		20	50	50	121	23
24	CENDER BLOCKS	1999	1,100		20	55	55	128	24
25	WINDOWS	1999	969		20	48	48	108	25
26	ROOF REPAIR	1999	950		20	48	48	108	26
27	CURTAIN DRAINS	1999	2,550		20	128	128	288	27
28	LANDSCAPING	1999	648		20	32	32	72	28
29	PARKING LOT REPAIR	1999	2,400		20	120	120	260	29
30	WATER RELIEF HOLE	1999	600		20	30	30	88	30
31	UNDERGROUND STORAGE	1999	2,200		20	110	110	303	31
32	ALARM REPAIRS	1999	1,242		20	62	62	171	32
33	CLOSED CIRCUIT TV'S	1999	711		20	36	36	72	33
34	TOTAL (lines 1 thru 33)		\$ 2,201,623	\$ 68,033		\$ 78,632	\$ 10,599	\$ 1,604,004	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
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19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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17								17
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,291,364	\$ 68,033		\$ 81,783	\$ 13,750	\$ 1,607,155	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
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26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 248,799	\$ 2,520	\$ 14,680	\$ 12,160		\$ 182,674	71
72	Current Year Purchases	83,105	35,656	11,458	(24,198)		11,458	72
73	Fully Depreciated Assets	246,563					246,563	73
74								74
75	TOTALS	\$ 578,467	\$ 38,176	\$ 26,138	\$ (12,038)		\$ 440,695	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Facility Business	1998 LEXUS	1998	\$	\$	\$	\$		\$
77	Facility Business	1998 LEXUS	1998	25,000		5,000	5,000		13,113
78	Facility Business	1990 DODGE VAN	1990	21,434	224		(224)		21,434
79									
80	TOTALS			\$ 46,434	\$ 224	\$ 5,000	\$ 4,776		\$ 34,547

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 3,016,265
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 106,433
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 112,921
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 6,488
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 2,082,397

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	1998 LEXUS - 1998	\$ 40,529	\$ 1,775	\$
87				
88				
89				
90				
91	TOTALS	\$ 40,529	\$ 1,775	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Alloc-ABH				5,544			5
6								6
7	TOTAL				\$ 5,544			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,293 Description: Pitney Bowes (postage machine) \$773; Air Savers (filters) \$4520

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<div>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?<div><input type="checkbox"/> YES<input checked="" type="checkbox"/> NO</div><div>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</div></div>	2. <u>CLASSROOM PORTION:</u>	3. <u>CLINICAL PORTION:</u>
	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
	HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5		6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist		hrs							4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy		# of prescripts							9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
13	Other (specify):									13		
14	TOTAL			\$		\$	\$		\$	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 187,672	\$ 255,533	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	878,374	878,374	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	291,434	291,434	5
6	Prepaid Insurance	49,045	49,045	6
7	Other Prepaid Expenses	365	365	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	67,832	67,832	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,474,722	\$ 1,542,583	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,202,294	2,202,294	15
16	Equipment, at Historical Cost	640,816	640,816	16
17	Accumulated Depreciation (book methods)	(2,364,154)	(2,364,154)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,495	10,495	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 589,451	\$ 589,451	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,064,173	\$ 2,132,034	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,867	\$ 84,867	26
27	Officer's Accounts Payable	4,238	4,238	27
28	Accounts Payable-Patient Deposits	86,052	86,052	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,841	71,841	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,456	88,288	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,809	75,809	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	259	259	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 343,522	\$ 411,354	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,101	280,101	39
40	Mortgage Payable	(1)	(1)	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 280,100	\$ 280,100	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 623,622	\$ 691,454	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,440,551	\$ 1,440,580	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,064,173	\$ 2,132,034	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 898,256	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 898,256	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	917,295	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(375,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 542,295	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,440,551	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,603,519	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,603,519	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	98,078	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 98,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,561	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,561	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	2,657	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,715,815	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	922,298	31
32	Health Care	1,221,130	32
33	General Administration	1,270,511	33
	B. Capital Expense		
34	Ownership	214,731	34
	C. Ancillary Expense		
35	Special Cost Centers	77,870	35
36	Provider Participation Fee	91,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,798,520	40
41	Income before Income Taxes (line 30 minus line 40)**	917,295	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 917,295	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BAYSIDE TERRACE# 0023036

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,113	2,202	\$ 67,945	\$ 30.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,121	4,266	48,852	11.45	3
4	Licensed Practical Nurses	14,580	16,721	299,144	17.89	4
5	Nurse Aides & Orderlies	34,900	38,268	323,655	8.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,923	9,597	102,462	10.68	10
11	Social Service Workers	18,277	19,744	249,921	12.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,114	23,693	227,582	9.61	15
16	Dishwashers					16
17	Maintenance Workers	3,860	4,563	74,319	16.29	17
18	Housekeepers	9,937	11,565	108,738	9.40	18
19	Laundry	2,001	2,201	18,088	8.22	19
20	Administrator	2,080	2,303	83,583	36.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,074	12,929	132,825	10.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,979	148,052	\$ 1,737,114 *	\$ 11.73	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 7,350	01-03	35
36	Medical Director	monthly	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,120	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	monthly	3,158	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	monthly	378	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,206		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	779	\$ 30,966	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	779	\$ 30,966		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Dementrea Rafael	Administrator		\$ 83,583
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,583
B. Administrative - Other			
Description			Amount
Health Resource Inc. - Management Fee			\$ 313,616
Karla Bishop, Inc. - Administrative Fee			243,177
AHB, Inc.			17,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 573,793
C. Professional Services			
Vendor/Payee	Type		Amount
Sachoff & Weaver	Legal		\$ 4,827
Frost, Ruttenberg & Rothblatt	Accounting		67,105
Lawrence Weber Medical	Computer Support Fees		2,105
Alpha Data	Data Processing		2,621
Jane Osa	Pension Admin. Fees		1,525
Rosig, Smith, Ericksen	Legal (adj. Page 5)		500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 78,683
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 22,249
Unemployment Compensation Insurance			8,456
FICA Taxes			132,889
Employee Health Insurance			32,123
Employee Meals			368
Illinois Municipal Retirement Fund (IMRF)*			
Union Health and Welfare			51,829
Employee Benefits			1,414
Allocated from AHB, Inc.			1,965
Holiday Expense			9,327
TOTAL (agree to Schedule V, line 22, col.8)			\$ 260,620
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 274
Advertising: Employee Recruitment			3,835
Health Care Worker Background Check (Indicate # of checks performed 5)			60
Advertising			3,771
Licenses and Fees			206
Special Dues - ICLTC			4,419
Duees and Subscriptions			1,378
Alloc - AHB, Inc			331
Less: Public Relations Expense			
Non-allowable advertising			(3,771)
Yellow page advertising			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 10,503
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			1,949
Seminar Expense			2,496
Entertainment Expense			
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 4,445

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number BAYSIDE TERRACE

0023036

Report Period Beginning:

01/01/01

Ending:

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. ICLTC - \$6778
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 91,980
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 368 Has any meal income been offset against related costs? yes Indicate the amount. \$ 368
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 14
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees